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(validate) validate)		-	
File Help Previous Next (Validate) Do you offer a Deductible? Yes Notat is the amount of your Deductible? Medicare-Defined Part A Deductible amount Medicare-Defined Part B Deductible amount Medicare-Defined Part A and B Deductible Medicare-Defined Part A and B Deductible Other, Indicate amount Indicate Deductible Amount: Medicare-Defined Medicare-defined Part A and B Deductible applied? Single Deductible Differentially applied to Part A and Part B Medicare-services, reflecting Original Medicare payment structure. LPPO and RPPO plans must include ALL OON Medicare- covered Services in the Deductible, 14a preventive services may not be included in the in-Network deductible. If the zood original Medicare amounts, please verify that any differential deductible amounts that are selected will not exceed the 2020 Original Medicare amounts that will be released by CMS.	Go To: Plan Deductible LPPO/RPPO Base 1 Do you include 14a Medicare-covered Zero Dollar Preventive Services as part of your OON Medicare-covered Services Deductible? Yes No Selectthe Service Categories that apply to your Deductible (Optional): h-Network Medicare-covered benefits Out-of-Network Non-Medicare-covered benefits Out-of-Network Medicare-covered Service Categories to which the Deductible apply to all In-Network Medicare-covered Service Categories to which the Deductible applysion Select all of the In-Network Medicare-covered Service Categories to which the Deductible applies: Select all of the In-Network Medicare-covered Service Categories to which the Deductible applies: Select all of the In-Network Medicare-covered Service Categories to which the Deductible applies: Select all of the In-Network Medicare-covered Service Categories to which the Deductible applies: Select all of the In-Network Medicare-covered Service Categories to which the Deductible applies: Select all of the In-Network Medicare-covered Service Categories to which the Deductible applies: Select all of the In-Network Medicare-covered Service Categories to which the Deductible applies: Select all of the In-Network Medicare-covered Service Categories to which the Deductible applies: Select All of the In-Network Medicare-covered Service Categories to which the Deductible applies: Select All of the In-Network Medicare-covered Service Categories to which the Deductible applies: Select All of the In-Network Medicare-covered Services Select All Information Services Select All Information Services Select All Information Services Select All Deservices Select All Deservices Select All Deservices Select All Deservices Select All Deser		
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revious Next	Exit (Validate)	Exit (No Validate)	Go To:	Plan Deductible LPPO/RPPO Base 2	
old down the CTRL key o bottons with your MOUSE. TRL key on your keyboar Does the Deductible app benefits? Yes No Select all of the In-Netw to which the Deductible 1a: Inpatient Hospital-Pa 2: Skilled Nursing Facility 3-1: Cardiac Rehabilitä 3-2: Intensive Cardiac R 3-3: Pulmonary Rehabilit 3-4: SET for PAD Servic 4: Worldwide Emergen 7: Chiorpractic Services 9d: Outpatient Blood Ser 10b: Transportation Ser 13b: Over-the-Counter (13c: Meal Benefit 13d: Other 1 13e: Other 2 13f: Other 3 13g: Dual Eligible SNPs v 14b: Annual Physical Ex 14c: Other Defined Sup 15: Medicare Part B Rx 1 16a: Preventive Dental 16b: Comprehensive De 17a: Eye Exams 17b: Eyewear	After selecting ALL of d. ly to all In-Network N ork Non-Medicare-o applies: ute vchiatric v (SNF) on Services ehabilitation Services ation Services es browners es cy/Urgent Coverage s vices OTC) Items with Highly Integrated am plemental Benefits Drugs	of your options Non-Medicare-c covered Service	release the covered	Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on yo keyboard. Does the Deductible apply to all Out-of-Network Non-Medicare-covered benefits? No Select all of the Out-of-Network Non-Medicare-covered Service Categories to which the Deductible applies: 1a: Inpatient Hospital-Acute 1b: Inpatient Hospital-Acute 1b: Inpatient Hospital-Acute 1b: Inpatient Hospital-Acute 1b: Inpatient Hospital-Services 3-2: Intensive Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 3-4: SET for PAD Services 4: Worldwide Emergency/Urgent Coverage 7b: Chiropractic Services 9d: Outpatient Blood Services 10b: Transportation Services 13a: Acupuncture 13b: Over-the-Counter (OTC) Items 13d: Other 1 13e: Other 3 13g: Dual Eligible SNPs with Highly Integrated Services 14b: Annual Physical Exam 14c: Other Defined Supplemental Benefits 15f: Medicare Part B Rx Drugs 16a: Preventive Dental 17b: Eyewear	

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Do you have di	ifferential serv	ice category-level	deductibles in a	ddition to			
your In-Networ	rk Plan-level E	Deductible?					
C No							
	our MOUSE.	n your keyboard wh After selecting ALL d.					
Select all of apply:	the Service C	ategories to which	the differential	deductibles	н		
1a: Inpatient	t Hospital-Acut t Hospital Psyc			,	^		
2: Skilled Nu	rsing Facility (SNF)					
4c: Worldw	ide Emergency	Rehabilitation Servio //Urgent Coverage	ces				
	spitalization alth Services						
7a: Primary	Care Physiciar	n Services					
	actic Services tional Therapy	Sanviana					
	in Specialist Se						
7e: Mental H	lealth Specialty						
7f: Podiatry	Services ealth Care Prof	fessional					
	tric Services	lessional					
		Speech-Language P	athology Servic	es			
	reatment Progr	ram Services /Tests/Lab Service:					
		Therapeutic Radiolo					
	ient Hospital S						
	vation Services ory Surgical Co	s enter (ASC) Service			v		
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-Acute Services	Tiers 1, 2, and	Amounts for Inpa Amounts for Inpa and 3, where approp	riate: atient Hospital propriate: led Nursing	Indicate Differential Deductible Amount for Cardiac and Pulmonary Rehabilitation Services: Indicate Differential Deductible Amount for Worldwide Emergency/Urgent Coverage: Indicate Differential Deductible Amount for Partial Hospitalization: Indicate Differential Deductible Amount for Home Health Services: Indicate Differential Deductible Amount for Primary Care Physician Services: Indicate Differential Deductible Amount for Chiropractic Services: Indicate Differential Deductible Amount for Occupational Therapy Services: Indicate Differential Deductible Amount for Physician Specialist Services: Indicate Differential Deductible Amount for Physician Specialist Services:	Note: No single Differential Deductible can be greater than the deductible. The total of all of the Differential Deductibles can be greater than the deductible.

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Indicate Differential Deductible Amount for Mental Health Specialty Services - Non-Psychiatric:	Indicate Differential Deductible Amount for Outpatient Diagnostic and Therapeutic Radiological Services:	Indicate Differential Deductible Amount for Ground Ambulance Services:	Indicate Differential Deductible Amount for Dialysis Services:
Indicate Differential Deductible Amount for Podiatry Services:	Indicate Differential Deductible Amount for Outpatient Hospital Services:	Indicate Differential Deductible Amount for Air Ambulance Services:	Indicate Differential Deductible Amount for Acupuncture:
Indicate Differential Deductible Amount for Other Health Care Professional Services:	Indicate Differential Deductible Amount for Observation Services:	Indicate Differential Deductible Amount for Transportation Services:	Indicate Differential Deductible Amount for OTC:
Indicate Differential Deductible Amount for Psychiatric Services:	Indicate Differential Deductible Amount for Ambulatory Surgical Center (ASC) Services:	Indicate Differential Deductible Amount for Durable Medical Equipment (DME):	Indicate Differential Deductible Amount for Meal Benefit:
Indicate Differential Deductible Amount for Physical Therapy and Speech- Language Pathology Services:	Indicate Differential Deductible Amount for Outpatient Substance Abuse:	Indicate Differential Deductible Amount for Prosthetics/Medical Supplies:	
Indicate Differential Deductible Amount for Opioid Treatment Program Services:	Indicate Differential Deductible Amount for Outpatient Blood Services:	Indicate Differential Deductible Amount for Diabetic Supplies and Services:	
Indicate Differential Deductible Amount for Outpatient Diagnostic Procedures and Test and Lab Services:			

e Help				
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ndicate Differential or Other 1:	Deductible Amount	Indicate Differential Deductible Amount for Kidney Disease Education Services		Indicate Differential Deductible Amount for Hearing Exams:
ndicate Differential or Other 2:	Deductible Amount	Indicate Differential Deductible Amount for Medicare-covered Glaucoma Screening Services:	Indicate Differential Deductible Amount for Medicare Part B Rx Drugs:	Indicate Differential Deductible Amount for Hearing Aids:
ndicate Differential or Other 3:	Deductible Amount	Indicate Differential Deductible Amount for Medicare-covered Diabetes Self- management Training:	Indicate Differential Deductible Amount for Preventive Dental:	
ndicate Differential or Dual Eligible SNI htegrated Services	Deductible Amount Ps with Highly	Indicate Differential Deductible Amount for Medicare-covered Barium Enemas	Indicate Differential Deductible Amount for Comprehensive Dental:	
ndicate Differential or the Annual Phys	Deductible Amount ical Exam:	Indicate Differential Deductible Amount for Medicare-covered Digital Rectal Exams	Indicate Differential Deductible Amount for Eye Exams:	
	Deductible Amount pplemental Benefit	Indicate Differential Deductible Amount for Medicare-covered EKG following Welcome Visit	Indicate Differential Deductible Amount for Eyewear:	

Deductible for LPPO/RPPO Mandatory Supplemental Benefits – Base 1

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you offer a mandatory enhanced benefit enrolled	e deductible amount?	Indicate deductible for one or more of the follow	ing services		
Yes No			Deductible Amount		
Select the mandatory enhanced benefits that hav deductible:	ve an enrollee	Inpatient Hospital-Acute			
1a: Inpatient Hospital-Acute 1b: Inpatient Hospital Psychiatric 2: Skilled Nursing Facility (SNF)	^	Inpatient Hospital Psychiatric			
3: Cardiac and Pulmonary Rehabilitation Services 4c: Worldwide Emergency/Urgent Coverage		Skilled Nursing Facility (SNF)			
7b: Chiropractic Services 7f: Podiatry Services 9d: Outpatient Blood Services		Cardiac and Pulmonary Rehabilitation Services	;		
10b: Transportation Services 13a: Acupuncture 13b: Over-the-Counter (OTC) Items		Worldwide Emergency/Urgent Coverage			
13c: Meal Benefit 13d: Other 1		Chiropractic Services			
13e: Other 2	~	Podiatry Services - Routine Foot Care			
		Outpatient Blood Services			
		Transportation Services			
		Acupuncture			
		Over-the-Counter (OTC) Items			
		Meal Benefit			

Deductible for LPPO/RPPO Mandatory Supplemental Benefits – Base 2

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Indicate deducti	ble for one or	more of the follow	ing services						
		Deducti Amount							
Other 1									
Other 2									
Other 3									
Dual Eligible SN Integrated Servi	P with Highly ces	(
Annual Physica	l Exam								
Other Defined S	upplemental	Benefi							
Preventive Dent	al								
Comprehensive	Dental								
Eye Exams									
Eyewear									
Hearing Exams									
Hearing Aids									

Plan Deductible (In-Network)

File Help	try system - s	Section D, Contra	ct X0001, Plan 00	1, Segme	nt 000	-	\times
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C Yes No Indicate In-N Select the ber In-Network	e the Medicar Network Plan D Nefits that appi K Medicare-cov K Non-Medicar etwork Deduct	e-defined Part B [Deductible Amoun ly to the In-Netwo vered benefits re-covered benefit tible apply to all In	rk Deductible: Is		Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard. Select all of the In-Network Medicare-covered Service Categories to which the In-Network Plan Deductible applies: 1a: Inpatient Hospital Psychiatric 2: Skilled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services 3-2: Intensive Cardiac Rehabilitation Services 3-4: SET for PAD Services 3-4: SET for PAD Services 0: Yes No		

Plan Deductible (Combined) – Base 1

-	🔜 PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000 – File Help								
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	Plan Deductible (Combined) - Base 1	•			
 ○ Yes ○ No Indicate Combin Amount: Select the benefit □ In-Network M □ In-Network N ○ Out-of-Netwo ○ Out-of-Netwo ○ Out-of-Netwo 	he Medicare ed (In-Netw edicare-cov on-Medicare rk Medicare rk Non-Med	-defined Part B D ork and Out-of-Ne r to the Combinec ered benefits -covered benefits	eductible amour etwork) Deductib d Deductible: s nefits	nt?	Hold down the CTRL key on your keyboard while selecting ALL of your options release the CTRL key on your keyboard. Select all of the In-Network Medicare-covered Service Categories to which the Combined Deductible applies. Ta: Inpatient Hospital-Acute The Inpatient Hospital-Acute The Inpatient Hospital Psychiatric 2: Skilled Nursing Facility (SNF) 3: Cardiac Rehabilitation Services 3: Pulmonary Rehabilitation Services 3: Pulmonary Rehabilitation Services 3: Pulmonary Rehabilitation Services 3: Pulmonary Rehabilitation Services 3: Partial Hospital-Acute Covered plan services? Covered plan services? No Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard. Select all of the In-Network Non-Medicare-covered Service Categories to which the Combined Deductible applies: 11: Inpatient Hospital-Acute 11: Inpatient Hospital-Acute 12: Skilled Nursing Facility (SNF) 3: 1: Cardiac Rehabilitation Services 3: 2: Intensive Cardiac Rehabilitation Services 3: 4: SET for PAD Services 3: 4: SET for PAD Services 3: 6: Uurotation Services 3: 6: Uurotation Services 3: 6: Uurotation Services 3: 7: Podiatry Services 3: 9: Outpatient Blood Services 3: 9: Outpatient Blood Services 3: 0: Transportation Services 3: 0: Transportation Services 3: 0: Transportation Services 3: 0: Transportation Services				

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Plan Deductible (Combined) – Base 2

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covered plans	ervices? e CTRL key or your MOUSE. , your Keyboard ne Out-of-Netw mbin ed Deduc lospital-Acute lospital Psychia sing Facility (SM Cardiac Rehab ilfation St Cardiac Rehab ilfation St Cardiac Rehab y Rehabilitation AD Services pitalization h Services are Physician S tic Services are Physician S tic Services and Therapy Se Specialist Servi alth Specialty Se ervices th Care Profess c Services th Care Profess th Care Profess th Care Profest th Care Pro	ork Medicare-cov tible applies: ttric F) ervices ilitation Services Services ervices ervices ervices sional eech-Language Pat a Services services sets/Lab Services	nile selecting th of your option: ered Service C	e coverage s release the ategories to	Does the Combined Deductible apply to all Out-Of-Network Non-Medicare- covered plan services?		

Plan Deductible (Out-of-Network)

PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000 — [File Help									
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Out-of-Netv	e the Medicare ble amount? efits that apply vork Medicare vork Non-Med of-Network De	-defined to the Out-o -covered ben icare-covered ductible apply	Indicate Out-of-N Deductible Amoun f-Network Deductil efits	nt: ble:	Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard. Select all of the Out-of-Network Plan Deductible applies: 1a: Inpatient Hospital-Acute 1b: Inpatient Hospital Psychiatric 2: Skilled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services 3-2: Intensive Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 3-4: SET for PAD Services 3-4: SET for PAD Services 7 Yes No Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard. Select all of the Out-of-Network Non-Medicare-covered Service Categories to which the Out-of-Network Non-Medicare-covered Service Categories 1a: Inpatient Hospital-Acute 1a: Inpatient Hospital-Acute 1a: Inpatient Hospital Psychiatric 2: Skilled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services 3-2: Intensive Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 3-4: Worldwide Emergency/Urgent Coverage 7: Podiatry Services 9: Outpatient Blood Services 3: Outpatient Blood Services 3				

Softrams

Plan Deductible (Non-Network)

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Select the ben Medicare-o Non-Medic	e the Medicare ble amount? I Deductible Ar efits that apply covered benefii are-covered b	mount: y to the Deductibl		Hold down the CTRL key on your keyboard while selecting the coverage cTRL key on your keyboard. Select all of the Medicare-covered Service Categories to which the Plan Deductible applies: Ta: inpatient Hospital-Acute 1b: inpatient Hospital-Acute 3-4: SET for PAD Services 3-4: SET for PAD Services 3-4: SET for PAD Services 1c: Yes C No Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard. Select all of the Non-Medicare-covered Service Categories to which the Deductible applies. 1a: inpatient Hospital-Acute 1b: inpatient Hospital-Acute 1b: inpatient Hospital-Acute 1b: inpatient Hospital-Acute 1b: inpatient Hospital-Acute 1b: inpatient Hospital-Acute 2: Skiled Nursing Facility (SIKF) 3-4: SET for PAD Services 3-2: Intensive Cardiac Rehabilitation Services 3-4: SET for PAD Services 3-4: SET for PAD Services 7: Chiorparctic Services 7: Doldary Services 9: d: Uutpatient Hospital-Acute 1b: Transportation Services 9: d: Uutpatient Hospital-Services 7: Chiorparctic Services 7: Chiorparctic Serv		

Max Enrollee Cost Limit (In-Network)

PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 0	- 00		
e Help	lax Enrollee Cost Limit (In-Network)	ĩ	
Previous Next (Validate)		1	
 a there an In-Network Maximum Enrollee Out-of-Pocket Cost? Yes No Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level? C Voluntary Mandatory All MA plans must have a maximum out-of-pocket (MOOP) that covers all A/B services. For a list of the Voluntary and Mandatory Limits, please right-click on the "Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?" All MA plans must have a maximum out-of-pocket (MOOP) that covers all A/B services. For a list of the Voluntary and Mandatory Limits, please right-click on the "Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory level?" question and view the Variable Help. Note for D-SNPs: For purposes of submitting bids to CMS, D-SNPs must include Parts A, B, and Part D Medicare services in the PBP, along with approved optional and mandatory supplemental benefits. No Medicaid benefits may be included in the PBP. D-SNPs have the flexibility to establish \$0 as the MOOP amount, thereby guaranteeing there is no cost sharing for plan enrollees, including those who are liable for Medicare-covered services (or non-covered), it must track enrollees' out-of-pocket spending and it is up to the plan to develop the process and vehiclefor doing so. 	Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard. Select all of the In-Network Medicare-covered Service Categories that are INCLUDED in the In-Network Maximum Enrollee Out-of-Pocket Cost amount: 1a: Inpatient Hospital-Acute 1b: Inpatient Hospital-Acute 1b: Inpatient Hospital Psychiatric 2: Skilled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services 3-2: Intensive Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 3-4: SET for PAD Services 3-4: SET for PAD Services 3-4: SET for PAD Services 5: Partial Hospitalization 6: Home Health Services 7a: Primary Care Physician Services 7b: Chiropractic Services Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services? C Yes No		
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount: Note: For Regional PPOs, all Medicare Part A/B services must be included in the Maximum Enrollee Out-of-Pocket Cost.	Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard. Select all of the In-Network Non-Medicare-covered Service Categories that ar INCLUDED in the In-Network Maximum Enrollee Out-of-Pocket Cost amount. 1a: Inpatient Hospital-Acute 1b: Inpatient Hospital Psychiatric		
Select the benefits that apply to the In-Network Maximum Enrollee Out- of-Pocket cost: In-Network Medicare-covered benefits In-Network Non-Medicare-covered benefits Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	2: Skilled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services 3-2: Intensive Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 3-4: SET for PAD Services 4c: Worldwide Emergency/Urgent Coverage 6: Home Health Services 7b: Chiropractic Services 7c: Courgeting Theremy Services		
C Yes C No	7c: Occupational Therapy Services		

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Max Enrollee Cost Limit (Combined) – Base 1

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there a Combined (In-Network and Out-of-Network t-of-Pocket Cost? Yes No Syour Combined (In-Network and Out-of-Networ Dut-of-Pocket Cost at the Voluntary or Mandatory Valans only) Voluntary Mandatory WI MA plans must have a maximum out-of-pocket UB services. For a list of the Voluntary and Mand (ght-click on the "is your Combined Maximum En MOOP) Cost at the Voluntary or Mandatory level he Variable Help. Note for D-SNPs: For purposes of submitting bid nust include Parts A, B, and Part D Medicare serv long with approved optional and mandatory sup to Medicaid benefits may be included in the PBP exibility to establish S0 as the MOOP amount, th here is no cost sharing for Medicare-covered services (or no rack enrollees' out-of-pocket spending and it is u levelop the process and vehicle for doing so. ndicate Combined (In-Network and Out-of-Networ Jut-of-Pocket CostAmount: D-Network Non-Medicare-covered benefits Out-of-Network Medicare-covered benefits Out-of-Network Medicare-covered benefits Out-of-Network Non-Medicare-covered benefits Out-of-Network Medicare-covered benefits Out-of-Network Medicare-covered plan services?	rk) Maximum Enrollee y Level? (Network PFFS t (MOOP) that covers all latory Limits, please rollee Out-of-Pocket ?" question and view is to CMS, D-SNPs vices in the PBP, vices	Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard. Select all of the In-Network Medicare-covered Service Categories that are INCLUDED in the Combined Maximum Enrollee Out-of Pocket CostAmount Opes the Combined Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services? C Yes No Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTR key on your keyboard. Select all of the In-Network Non-Medicare-covered Service Categories that are INCLUDED in the Combined Maximum Enrollee Out-of Pocket Cost Amount:

Max Enrollee Cost Limit (Combined) – Base 2

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covers all AB 5 Limits, please r Enrollee Out-o Mandatory lev/ Does the Comt to all Out-of-Ne C Yes C No Hold down the coverage optic options releas Select all of the Categories tha Enrollee Out-o 1a: Inpatient Ho 1b: Inpatient Ho 1b: Inpatient Ho 2: Skiled Nursi 3-1: Cardiac R 3-2: Intensive (3-3: Pulmonary 3-4: SET for PA 5: Partial Hospi 6: Home Health 7a: Primary Ca	services. For a ight-click on the f-Pocket (MOC el?" question a obied Maximum twork Medicar. "CTRL key on y ons with your M e Out-of-Network the CTRL key e Out-of-Network the relocation of Pocket Cost. ospital-Acute o	ric) vices tation Services Services rvices vices	y and Mandatory ed Maximum untary or be Help. Pocket Cost appl rvices? Ie selecting the cting ALL of your d. red Service		Does the Combined Maximum Enrollee Out-of-Pocket Cost apply to all Out-of-Network Non-Medicare-covered plan services?			

Max Enrollee Cost Limit (Out-of-Network)

File Help	
Previous Next (Validate) Go To: Max E	inrollee Cost Limit (Out-of-Network)
Is there an Out-of-Network Maximum Enrollee Out-of-Pocket Cost? C Yes C No	Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.
Is your Out-of-Network Maximum Enrollee Out-of-Pocket Cost Lower, Intermediate or Mandatory?	Select all of the Out-of-Network Medicare-covered Service Categories that are INCLUDED in the Out-of-Network Maximum Enrollee Out-of-Pocket Cost amount:
C Lower C Intermediate C Mandatory	1a: Inpatient Hospital-Acute A 1b: Inpatient Hospital Psychiatric 2: Skilled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services A
All MA plans must have a maximum out-of-pocket (MOOP) that covers all A/B services. For a list of the Lower, Intermediate and Mandatory Limits, please right-click on the "Is your Out-of-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory level?" question and view the Variable Help.	3-2: Intensive Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 3-4: SET for PAD Services 5: Partial Hospitalization 6: Home Health Services 7a: Primary Care Physician Services
Indicate the Out-of-Network Maximum Enrollee Out-of-Pocket Cost Amount:	7a: Primary Care Physician Services 7b: Chiropractic Services 7c: Occupational Therapy Services
Select the benefits that apply to the Out-of-Network Maximum Enrollee Out-of-Pocket cost:	Does the Out-of-Network Maximum Enrollee Out-of-Pocket Cost apply to all Out-of-Network Non-Medicare-covered plan services?
Out-of-Network Medicare-covered benefits	C Yes
Out-of-Network Non-Medicare-covered benefits	C No
Note: For Regional PPOs, all Medicare Part A/B services must be included in the Maximum Enrollee Out-of-Pocket Cost.	Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.
Does the Out-of-Network Maximum Enrollee Out-of-Pocket Cost apply to all Out-of-Network Medicare-covered plan services?	Select all of the Out-of-Network Non-Medicare-covered Service Categories that are INCLUDED in the Out-of- Network Maximum Enrollee Out-of-Pocket Cost amount:
C Yes C No	1a: Inpatient Hospital-Acute 1b: Inpatient Hospital Psychiatric 2: Skilled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services 3-2: Intensive Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 3-4: SET for PAD Services 4:: Worldwide Emergency/Urgent Coverage
	7b: Chiropractic Services 7f: Podiatry Services 9d: Outpatient Blood Services 10b: Transportation Services

Max Enrollee Cost Limit (Non-Network)

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Vious	Next	Exit (Validate)	Exit (No Validate)	Go To: 🔟	lax Enrollee Cost Limit (Non-Network)
ur Maximu latory leve		ut-of-Pocket (MOC	OP) Cost at the '	Voluntary or	Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.
Voluntary Mandatory					Select all of the Medicare-covered Service Categories INCLUDED in the
I MA plans n B services. I ght-click on IOOP) Cost e Variable H	nust have a ma For a list of the the "Is your Co at the Voluntar elp.	aximum out-of-po e Voluntary and M ombined Maximun ry or Mandatory Ie llee Out-of-Pocket	landatory Limits n Enrollee Out-o evel?" question	, please f-Pocket	Maximum Enrollee Out-of-Pocket Cost Amount: 1a: Inpatient Hospital-Acute Ib: Inpatient Hospital-Psychiatric Skilled Nursing Facility (SNF) Cardiac Rehabilitation Services Cardiac Rehabilitation Services Sa: Pulmonary Rehabilitation Services Set SET for PAD Services SET or PAD Services Vertices
Select the ben	efits that apply	v to the Maximum	Enrollee Out-of	-Pocket cost	Does the Maximum Enrollee Out-of-Pocket Cost apply to all Non-Medicare- covered plan services?
Select the benefits that apply to the Maximum Enrollee Out-of-Pocket cost: Medicare-covered benefits Non-Medicare-covered benefits			C Yes C No		
oes the Maxi		Out-of-Pocket Co	ost apply to all N	Medicare-	Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.
) Yes					Select all of the Non-Medicare-covered Service Categories INCLUDED in the Maximum Enrollee Out-of-Pocket Cost Amount:
<u>No</u>					1a: Inpatient Hospital-Acute 1b: Inpatient Hospital Psychiatric 2: Skilled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services 3-2: Intensive Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 3-4: SET for PAD Services 4: SET for FAD Services 4: SET for FAD Services 7b: Chiropractic Services 7f: Podiatry Services 9d: Outpatient Blood Services Y

Max Plan Benefit Coverage

💀 PBP Data Entry System -	Section D, Contra	ct X0001, Plan 00	01, Segment 000	_	\times
File Help					
Previous Next	Exit (Validate)	Exit (No Validate)	Go To: Max Plan Benefit Coverage		
Previous Next The Maximum Plan Benefit C covered benefits. Is there a Maximum Plan Benefit C No Indicate Maximum Plan Benefit C No Indicate Maximum Plan Benefit C Select Maximum Plan Benefit C Select Maximum Plan Benefit C Every three years C Every three years C Every three years C Every three months C Other, Describe Select the benefits that ap Coverage Amount: In-Network Non-Medic Out-of-Network Non-Medic Out-of-Network Non-Medic	Exit (Validate) Coverage refers to enefit Coverage An enefit Coverage Am nefit Coverage Am ply to the Maximur are-covered benefi	Validate) Non-Medicare- nount? nount: ount Periodicity: m Plan Benefit its	Does the Maximum Plan Benefit Coverage amount apply to all In-Network Non-Medicare-covered plan services? Yes No Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard. Select all of the In-Network Non-Medicare-covered Service Categories to which the Maximum Plan Benefit Coverage Amount applies: Atternational Action		

Max Plan Benefit Coverage (Non-Network)

星 PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000 — 🗆 🛛 👋						
File Help Previous Next (Validate) Exit (No Validate)	Go To: Max Plan Benefit Coverage (Non-Network)	•				
The Maximum Plan Benefit Coverage refers to Non-Medicare- covered benefits. Is there a Maximum Plan Benefit Coverage Amount? Yes No Indicate Maximum Plan Benefit Coverage Amount Periodicity Select Maximum Plan Benefit Coverage Amount Periodicity Every three years Every six months Every six months Other, Describe	C Yes No No Sect all of the Non-Medicare-covered Service Categories to which the CTRL key on your keyboard while selecting the coverage of the key on your keyboard. Sect all of the Non-Medicare-covered Service Categories to which the CTRL key on your keyboard. The patient Hospital Acute By patient Hospital Psychiatric Skilled Nursing Facility (SNF) 3-1 Centaic Rehabilitation Services 3-2 Humonary Rehabilitation Services					

Plan Premium/Rebate Reduction

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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	Plan Premium/Rebate Reduction	•	
Indicate Plan P	remium Amou	nt (Part A/B):					
Indicate Plan P	remium Amou	nt (B Only):					
Are you using a reduce the Part	ny of your pla B Premium?	an's MArebates to					
O Yes O No							
Indicate the P	art B Premium	reduction amount:					

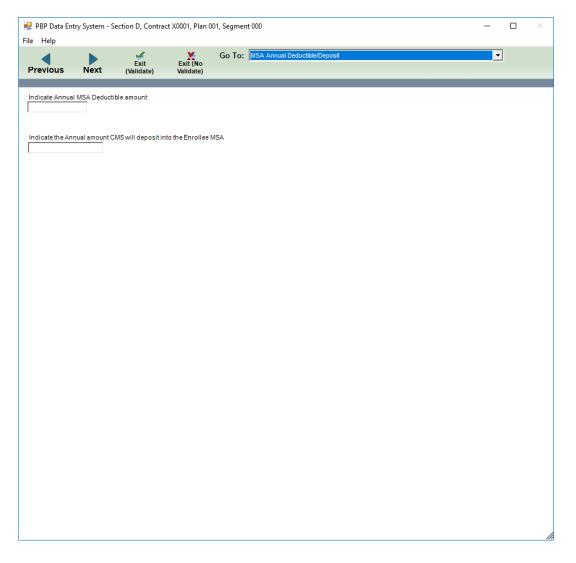
MMP – Medicaid/plan covered cost sharing

PBP Data Entry System - Section D, Contract X0001, P ile Help	an 001, Segment 000	>
Previous Next (Validate) Validat		
Do you offer any Non-Medicare-covered benefits (i.e., ser covered by Medicare)? Yes No Hold down the CTRL key on your keyboard while selecting options with your MOUSE. After selecting ALL of your opti CTRL key on your keyboard. Select all of the benefits that are covered under Medicaid: 1a1: Additional Days for Inpatient Hospital-Acute 1a2: Non-Medicare-covered Stay for Inpatient Hospital-Acute 1b1: Additional Days bro Inpatient Hospital-Acute 1b1: Additional Days bro Inpatient Hospital Psychiatric 1b2: Non-Medicare-covered Stay for Inpatient Hospital Psyc 2-1: Additional Days broyn Medicare-covered for Skilled Nursing Facility (3-1: Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 3-4: SET for PAD Services 4-2: Worldwide Euregency Coverage 4-2: Worldwide Euregency Transportation 6-1: Additional Hours of Care 6-3: Other 1 for Home Health Services 6-4: Other 2 for Home Health Services 7-1: Cocupational Therapy Services 7-1: Cocupational Therapy Services 7-1: Other 1 for PT and SP Services 71: Other 1 for PT and SP Services 71: Other 1 for PT and SP Services 72: Other 2 for PT and SP Services 73: Outpatient Blood Services 74: Outpatient Blood Services	services not covered by Medicare or Medicaid): 1a1: Additional Days for inpatient Hospital-Acute 1a2: Non-Medicare-covered Stay for Inpatient Hospital-Acute 1a3: Upgrades for Inpatient Hospital-Acute 1b2: Non-Medicare-covered Stay for Inpatient Hospital Psychiat 2-1: Additional Days beyond Medicare-covered for Skilled Nursin 2-2: Non-Medicare-covered Stay for Skilled Nursin 2-2: Non-Medicare-covered Stay for Skilled Nursin 3-2: Intensive Cardiac Rehabilitation Services 3-4: SET for PAD Services 3-4: SET for PAD Services 3-4: SET for PAD Services 4-c1: Worldwide Emergency Coverage 4-c2: Worldwide Emergency Transportation 4-c3: Worldwide Em	ric ng Facility (SN

PFFS Balance Billing

🔢 PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000	– 🗆 ×
File Help	
Previous Next (Validate) Validate) Go To: PFFS Balance Billing	•
Do you permit balance billing? Balance Billing is a percentage of plan payment rate provider may collect. No Collect. Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard. What category of providers do you permit to balance bill? Ts: inpatient Hospital-Acute 1b: inpatient Hospital-Acute 1b: inpatient Hospital-Acute 1c: inpatient Hospital-Acute 1c: solid downs yreading Killston Services 3: Pulmoary Rehabilitation Services 3: Pulmoary Rehabilitation Services 4: Emergency/Post-Stabilization Services 5: Partial Hospital-Acute b: Urgently Needed Services 7: Partial Hospital-Beyclites 6: Word Mode Emergency/Urgent Coverage 5: Partial Hospitalization 7: Occupational Therapy Services 7: Coupational Therapy Services 7: Occupational Therapy Services 7: Physician Specialist Services 7: Physician Specialist Services 7: Physician Specialist Services 7: Opticit Therapy and Speech-Language Pathology Services 7: Opticit Therapy and Speech-Language Pathology Services 7: Diputatint Diagnostic/Therapeutic Radiological Servi	Enter Minimum percentage for balance billing:

MSA Annual Deductible/Deposit



Reductions in Cost Sharing #1 – Base 1

🖳 PBP Data Entry System - Section D, Contract X0)1, Plan 001, Segment 000	
	Go To: Reductions in Cost Sharing #1 - Base 1 it (No idate)	T
Do you offer Reductions in Cost Sharing? Yes No How many groups of Reductions in Cost Sharing are you offering? C 1 C 2 C 3 Select the benefits that apply to the Reductions in Cost Sharing benefit: Medicare-covered benefits Non-Medicare covered benefits	Hold down the CTRL key on your keyboard while selecting options with your MOUSE. After selecting ALL of your optio CTRL key on your keyboard. Select which Medicare-Covered Services your Reductions apply to: 1s: Inpatient Hospital-Acute 1b: Inpatient Hospital-Acute 2: Skilled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services 3-2: Intensive Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 3-4: SET for PAD Services 4-3: Emergency/Post-Stabilization Services 4-4: SET for PAD Services 5: Partial Hospitalization 6: Home Health Services 7-a: Primary Care Physician Services 7-a: Primary Care Physician Services 7-b: Chiropractic Services 7-c: Cocupational Therapy Services 7-f: Individual Sessions for Mental Health Specialty Services 7-f: Individual Sessions for Mental Health Specialty Services 7-f: Podiatry Services 7-g: Other Health Care Professional 7-th: Individual Sessions for Psychiatric Services 7-b: Group Sessions for Psychiatric Services 7-b: Physical Therapy and Speech-Language Pathology Servic 7-c Physical Cardiological Services 8-a1: Diagnostic Procedures/Tests 8-a2: Lab Services 8-b1: Diagnostic Radiological Services	s Select which Non-Medicare Covered Services yo Select which Non-Medicare Covered Services yo 1a: Inpatient Hospital-Acute 1b: Inpatient Hospital Psychiatric 2: Skilled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services 3-2: Intensive Cardiac Rehabilitation Services 3-2: Intensive Cardiac Rehabilitation Services 3-4: SET for PAD Services 4-c1: Worldwide Emergency Coverage 4-c2: Worldwide Emergency Coverage 4-c2: Worldwide Emergency Transportation 7b1: Routine Chiropractic Care 7b2: Other Chiropractic Care 7b2: Other Chiropractic Services - Plan Approved He 10b1: Transportation Services - Plan Approved He 10b2: Transportation Services - Any Health-relate 13a: Acupuncture 13b: Over-the-Counter (OTC) Items 13c: Meal Benefit 13d: Other 1 13e: Other 3

Reductions in Cost Sharing #1 – Base 2

File Help Previous Next Constructions in Cost Sharing 1 Indicate Max Plan Benefit amount: Indicate Max Plan Benefit amount: Select Reductions in Cost Sharing periodicity: Every star months Other (describe)	💀 PBP Data Entry System - See	ction D, Contrac	t X0001, Plan 0	01, Segment	000	_	\times
Reductions in Cost Sharing 1 Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Indicate Max Plan Benefit amount: Notes: Select Reductions in Cost Sharing periodicity: Notes: © Every three months Every six months © Every year Can the reduction in cost sharing be applied to a deductible? Or Yes Notes: What is your Reductions in Cost Sharing mode of delivery? Debit Card Reimbursement Every in Reductions in Cost Sharing mode of delivery?	• •	Exit	Exit (No Validate)	Go To:	Reductions in Cost Sharing #1 - Base 2		
	Reductions in Cost Sharing 1 Indicate Max Plan Benef Select Reductions in Cos C Every three months C Every six months C Every year Can the reduction in coss Yes No What is your Reductions Debit Card Reimbursement	it amount: st Sharing period tsharing be appl	licity: ied to a deducti		category. Do not repeat information captured in data entry.		~
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Reductions in Cost Sharing #2 – Base 1

	a Entry System - Se	ction D, Contra	ct X0001, Plan 0	01, Segmen	ment 000 — 🗆	×
ile Help						
Previou	s Next	Exit (Validate)	Exit (No Validate)	Go To:	C: Reductions in Cost Sharing #2 - Base 1▼	
Sele Cos M Holo opti CFF Sele app 1a: 1b: 2 S Sele app 1a: 12: S 3-1: 3-2: 3-3: 3-4: 3-3: 3-4: 3-3: 3-4: 7-5: P 6: H 76: 76: 76: 76: 77: 77: 77: 77: 77: 77:	s in Cost Sharing 2 st the benefits that a Sharing benefit: edicare-covered bk on-Medicare cover down the CTRL ke ons with your MOUS L key on your keyb st which Medicare-(yto: apatient Hospital-Ac patient Hospital-Ac patient Hospital-Ac regative Rehabilitation Intensive Cardiac Re Pulmonary Rehabilitation Intensive Cardiac Re Pulmonary Rehabilitation me Heath Services Ser for PAD Service Services Cordiac Revice: Occupational Therap thysician Specialist 1 individual Sessions Group Sessions for oysical Therapy and ploid Treatment Pro- Diagnostic Procedu Lab Services Diagnostic Radiolog	apply to the Redu enefits ed benefits y on your keyboo E. After selectin oard. Covered Services chiatric (SNF) n Services shabilitation Servic tion Services shabilitation Services sy Services services for Mental Health Mental Health Sp ofessional for Psychiatric Sry Psychiatric Sry Psychiatric Sry Speech-Languag gram Services res/Tests	ard while selectin g ALL of your op s your Reduction ces s Specialty Services ervices ices	es	ease the	~

Reductions in Cost Sharing #2 – Base 2

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le Help						
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	Reductions in Cost Sharing #2 - Base 2	•
Reductions in					Note may include additional information to describe be category. Do not repeat information captured in data e	
Indicate	Max Plan Ben	efit amount:			Notes:	
O Ever	y three month y six months	ost Sharing period s	licity:			
Can the r C Yes C No	eduction in co	ost sharing be appl	ied to a deducti	ble?		
Debit Reimb	our Reduction Card pursement (describe)	s in Cost Sharing	mode of deliver	y?		

Reductions in Cost Sharing #3 – Base 1

File Help	
Go To: Reductions in Cost Sharing #3 - Base 1	-
Previous Next (Validate) Validate)	
(_
Reductions in Cost Sharing 3	
-	
Select the benefits that apply to the Reductions in	
Cost Sharing benefit:	
Medicare-covered benefits	
Non-Medicare covered benefits	
Hold down the CTRL key on your keyboard while selecting the coverage	
options with your MOUSE. After selecting ALL of your options release the	
CTRL key on your keyboard.	
Select which Medicare-Covered Services your Reductions in Cost Sharing	
apply to: Select which Non-Medicare Covered Services your Reductions in C	ostSha
1a: Inpatient Hospital-Acute	
1b: Inpatient Hospital Psychiatric 1b: Inpatient Hospital Psychiatric 20: Ultrad Human English Children Hospital Psychiatric 20: Children Human English Children Human English Human Eng	
2: Skilled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services 3-1: Cardiac Rehabilitation Services	
3-1. Cardiac Renabilitation Services 3-2. Intensive Cardiac Rehabilitation Services 3-2.	
3-3: Pulmonary Rehabilitation Services 3-3: Pulmonary Rehabilitation Services	
3-4; SET for PAD Services 3-4; SET for PAD Services	
4a: Emergency/Post-Stabilization Services 4c1: Worldwide Emergency Coverage	
4b: Urgently Needed Services 4c2: Worldwide Urgent Coverage	
5: Partial Hospitalization 4c3: Worldwide Emergency Transportation	
6: Home Health Services 7b1: Routine Chiropractic Care	
7a: Primary Care Physician Services 7b2: Other Chiropractic Services	
7b: Chiropractic Services 7f: Podiatry Services	
7c: Occupational Therapy Services 10b1: Transportation Services - Plan Approved Health-related Location	n
7d: Physician Specialist Services - Any Health-related Location	
7e1: Individual Sessions for Mental Health Specialty Services 13a: Acupuncture	
7e2: Group Sessions for Mental Health Specialty Services 13b: Over-the-Counter (OTC) Items 7f: Podiatry Services 13c: Meal Benefit	
77: Poliary Services 132: Mean Benefit	
7b: Undividual Sessions for Psychiatric Services 13e: Other 2	
7h2: Group Sessions for Syschiatric Services 13f: Other 3	
7i: Physical Therapy and Speech-Language Pathology Services 14b: Annual Physical Exam	
7k: Opioid Treatment Program Services 14c1: Health Education	
8a1: Diagnostic Procedures/Tests 14c2: Nutritional/Dietary Benefit	
8a2: Lab Services 14c3: Additional Sessions of Smoking and Tobacco Cessation Counse	ing
8b1: Diagnostic Radiological Services Y 14c4: Fitness Benefit	

Reductions in Cost Sharing #3 – Base 2

File jelp Previous Next Cond Cond Reductions in Cost Sharing 3 Indicate Max Plan Benefit amount: Cond Select Reductions in Cost Sharing periodicity: Net: Can the reductions in Cost Sharing mode of delivery Path Can Path Can </th <th>Previous Next Exit (No Select Reductions in Cost Sharing periodicity: Select Reductions in Cost Sharing periodicity: Can the reduction in cost sharing be applied to a deductible? Can the reduction in cost sharing be applied to a deductible? Yes Not What is your Reductions in Cost Sharing mode of delivery? Debit Card Reimbursement</th> <th>💀 PBP Data Entry System - Section D, Contract X0</th> <th>0001, Plan 001, Segmer</th> <th>nt 000</th> <th>_</th> <th></th>	Previous Next Exit (No Select Reductions in Cost Sharing periodicity: Select Reductions in Cost Sharing periodicity: Can the reduction in cost sharing be applied to a deductible? Can the reduction in cost sharing be applied to a deductible? Yes Not What is your Reductions in Cost Sharing mode of delivery? Debit Card Reimbursement	💀 PBP Data Entry System - Section D, Contract X0	0001, Plan 001, Segmer	nt 000	_	
Previous Exit (No Validate) Reductions in Cost Sharing 3 Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Indicate Max Plan Benefit amount: Notes: Select Reductions in Cost Sharing periodicity: Notes: Select Reductions in Cost Sharing periodicity: Notes: Can the reduction in cost sharing be applied to a deductible? Notes: Yes No What is your Reductions in Cost Sharing mode of delivery? Debit Card Reimbursement Indicate of the cost Sharing mode of delivery?	Previous Next Exit (No Validate) Reductions in Cost Sharing 3 Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Indicate Max Plan Benefit amount:					
Reductions in Cost Sharing 3 Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Indicate Max Plan Benefit amount: Notes: Select Reductions in Cost Sharing periodicity: Notes: Cevery three months Note may include additional information captured in data entry. Can the reduction in cost sharing be applied to a deductible? Notes: Yes No What is your Reductions in Cost Sharing mode of delivery? Debit Card Reimbursement Notes:	Reductions in Cost Sharing 3 Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Indicate Max Plan Benefit amount: Notes: Select Reductions in Cost Sharing periodicity: Notes: Cevery three months Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Select Reductions in Cost Sharing periodicity: Notes: Can the reduction in cost sharing be applied to a deductible? Yes No Notes: What is your Reductions in Cost Sharing mode of delivery? Debit Card Reimbursement Reimbursement	Previous Next (Validate)	Exit (No	Reductions in Cost Sharing #3 - Base 2		
category. Do not repeat information captured in data entry. Indicate Max Plan Benefit amount: Notes: Select Reductions in Cost Sharing periodicity: Notes: © Every three months Every three months © Every six months Every year Can the reduction in cost sharing be applied to a deductible? Notes: © Yes No What is your Reductions in Cost Sharing mode of delivery? Debit Card © Debit Card Reimbursement	Indicate Max Plan Benefit amount:		,			
		Previous Next (Validate) V Reductions in Cost Sharing 3 Indicate Max Plan Benefit amount:	r. to a deductible?	category. Do not repeat information captured in data entry.		

Combined Benefits #1

e Help		Section D, Contra		-			
revious	Next	Exit (Validate)	Exit (No Validate)	Go To:	Combined Benefits #1	•	
Select whic package: 1a: Inpatien 1b: Inpatien 2: Skilled Ni 3-1: Cardia 3-2: Intensi 3-3: Pulmor 4c1: World' 4c2: World' 4c3: World' 7b1: Routin	ch non-Medice at Hospital-Acu th Hospital Psycursing Facility (c Rehabilitation ve Cardiac Ref ary Rehabilitat r PAD Services wide Emergenc wide Urgent Co wide Emergenc chiropractic St	te chiatric (SNF) I Services nabilitation Services ion Services s cy Coverage cy Coverage cy Transportation Care	s are included ir		Select the number of Combined Supplemental Benefit packages you are offering?		
10b2: Trans 13a: Acupu Do you offe	sportation Serv Incture	vices - Plan Approv vices - Any Health-i Supplemental Bene nount?	elated Location		~		
C Yes C No	n Benefit Amor						
		one or more of the e which they must					

Combined Benefits #2

	4	×	Go To:	Combined Benefits #2			-	
revious Next	Exit (Validate)	Exit (No Validate)						
Select which non-Medi	care covered benefits a	are included in	your Comb	ined Supplemental Ber	nefit			
package:					_			
1a: Inpatient Hospital-Ad 1b: Inpatient Hospital Ps					^			
2: Skilled Nursing Facility	y (SNF)							
3-1: Cardiac Rehabilitati 3-2: Intensive Cardiac R								
3-3: Pulmonary Rehabilit	ation Services							
3-4: SET for PAD Servic								
4c1: Worldwide Emerge 4c2: Worldwide Urgent								
4c3: Worldwide Emerge	ncy Transportation							
7b1: Routine Chiropract	ic Care							
7b2: Other Chiropractic 7f: Podiatry Services	Services							
7b2: Other Chiropractic 7f: Podiatry Services 10b1: Transportation Se	Services ervices - Plan Approved		Location					
7b2: Other Chiropractic 7f: Podiatry Services 10b1: Transportation Se	Services		Location		*			
7b2: Other Chiropractic 7f: Podiatry Services 10b1: Transportation Se 10b2: Transportation Se 13a: Acupuncture	Services ervices - Plan Approved ervices - Any Health-rela	ated Location			~			
7b2: Other Chiropractic 7f: Podiatry Services 10b1: Transportation Se 10b2: Transportation Se	Services - Plan Approved rvices - Any Health-rela d Supplemental Benefits	ated Location			¥			
7b2: Other Chiropractic 7f: Podiatry Services 10b1: Transportation Se 10b2: Transportation Se 13a: Acupuncture Do you offer Combinec maximum plan benefit C Yes	Services - Plan Approved rvices - Any Health-rela d Supplemental Benefits	ated Location			*			
7b2: Other Chiropractic 7f: Podiatry Services 10b1: Transportation Se 10b2: Transportation Se 13a: Acupuncture Do you offer Combined maximum plan benefit	Services - Plan Approved rvices - Any Health-rela d Supplemental Benefits	ated Location			~			
7b2: Other Chiropractic 7f: Podiatry Services 10b1: Transportation Se 10b2: Transportation Se 13a: Acupuncture Do you offer Combinec maximum plan benefit	Services - Plan Approved rivices - Plan Approved rivices - Any Health-rela d Supplemental Benefit: amount?	ated Location			~			
7b2: Other Chiropractic 7f: Podiatry Services 10b1: Transportation Se 10b2: Transportation Se 13a: Acupuncture Do you offer Combined maximum plan benefit O Yes O No	Services - Plan Approved rivices - Plan Approved rivices - Any Health-rela d Supplemental Benefit: amount?	ated Location			v			
7b2: Other Chiropractic 7f: Podiatry Services 10b1: Transportation Se 10b2: Transportation Se 13a: Acupuncture Do you offer Combined maximum plan benefit C Yes C No	Services - Plan Approved rivices - Plan Approved rivices - Any Health-rela d Supplemental Benefit: amount? iount: o one or more of the co	ated Location s with a shared mbined supple	d		~			
7b2: Other Chiropractic 7f: Podiatry Services 10b1: Transportation Se 10b2: Transportation Se 13a: Acupuncture Do you offer Combined maximum plan benefit C Yes C No Max Plan Benefit Am Is the enrollee limited to	Services - Plan Approved rivices - Plan Approved rivices - Any Health-rela d Supplemental Benefit: amount? iount: o one or more of the co	ated Location s with a shared mbined supple	d		~			
7b2: Other Chiropractic 7f: Podiatry Services 10b1: Transportation Se 10b2: Transportation Se 13a: Acupuncture Do you offer Combined maximum plan benefit O Yes O No Max Plan Benefit Am Is the enrollee limited th benefits from the packa	Services - Plan Approved rivices - Plan Approved rivices - Any Health-rela d Supplemental Benefit: amount? iount: o one or more of the co	ated Location s with a shared mbined supple	d		~			
7b2: Other Chiropractic 77: Podiatry Services 10b1: Transportation Se 10b2: Transportation Se 13a: Acupuncture Do you offer Combined maximum plan benefit C Yes Max Plan Benefit Am Is the enrollee limited th benefits from the packa C Yes	Services - Plan Approved rivices - Plan Approved rivices - Any Health-rela d Supplemental Benefit: amount? iount: o one or more of the co	ated Location s with a shared mbined supple	d		~			
7b2: Other Chiropractic 77: Podiatry Services 10b1: Transportation Se 10b2: Transportation Se 13a: Acupuncture Do you offer Combined maximum plan benefit C Yes Max Plan Benefit Am Is the enrollee limited th benefits from the packa C Yes	Services - Plan Approved rivices - Plan Approved rivices - Any Health-rela d Supplemental Benefit: amount? iount: o one or more of the co	ated Location s with a shared mbined supple	d		~			
7b2: Other Chiropractic 77: Podiatry Services 10b1: Transportation Se 10b2: Transportation Se 13a: Acupuncture Do you offer Combined maximum plan benefit C Yes Max Plan Benefit Am Is the enrollee limited th benefits from the packa C Yes	Services - Plan Approved rivices - Plan Approved rivices - Any Health-rela d Supplemental Benefit: amount? iount: o one or more of the co	ated Location s with a shared mbined supple	d		~			

Combined Benefits #3

Go To: Combined Benefits #3	PBP Data Entry System - Section D, (Help	Contract X0001, Plan 00)1, Segment	000			_	
package: 1a: Inpatient Hospital-Route 1b: Inpatient Hospital-Psychiatric 2: Skiled Nursing Facility (SNF) 3: 1: Cardiac Rehabilitation Services 3: 2: Intensive Cardiac Rehabilitation Services 3: 3: Pulmonary Rehabilitation Services 3: 4: SET for ApD Services 3: 4: SET for ApD Services 3: 4: SET for ApD Services 4: 2: Worldwide Emergency Coverage 4: 2: Worldwide Urgent Coverage 4: 2: Worldwide Emergency Transportation 7b: Other Chiropractic Care 7b: 2: Other Chiropractic Services 7f: Podiatry Services 10b1: Transportation Services - Plan Approved Health-related Location 10b2: Transportation Services - Any Health-related Location 10b2: Transportation Services - Any Health-related Location 10b2: Transportation Services - Any Health-related Location 10b2: Transportation Services - No Max Plan Benefit Amount: Image: Stress Image: Stress Image: Stress St he enrollee limited to one or more of the combined supplemental benefits must select in advance?			Go To: 🛛	Combined Benefits #3			•	
package: 1a: Inpatient Hospital-Route 1b: Inpatient Hospital-Psychiatric 2: Skiled Nursing Facility (SNF) 3: 1: Cardiac Rehabilitation Services 3: 2: Intensive Cardiac Rehabilitation Services 3: 3: Pulmonary Rehabilitation Services 3: 4: SET for ApD Services 3: 4: SET for ApD Services 3: 4: SET for ApD Services 4: 2: Worldwide Emergency Coverage 4: 2: Worldwide Urgent Coverage 4: 2: Worldwide Emergency Transportation 7b: Other Chiropractic Care 7b: 2: Other Chiropractic Services 7f: Podiatry Services 10b1: Transportation Services - Plan Approved Health-related Location 10b2: Transportation Services - Any Health-related Location 10b2: Transportation Services - Any Health-related Location 10b2: Transportation Services - Any Health-related Location 10b2: Transportation Services - No Max Plan Benefit Amount: Image: Stress Image: Stress Image: Stress St he enrollee limited to one or more of the combined supplemental benefits must select in advance?								
package: 1a: Inpatient Hospital-Route 1b: Inpatient Hospital-Psychiatric 2: Skiled Nursing Facility (SNF) 3: 1: Cardiac Rehabilitation Services 3: 2: Intensive Cardiac Rehabilitation Services 3: 3: Pulmonary Rehabilitation Services 3: 4: SET for ApD Services 3: 4: SET for ApD Services 3: 4: SET for ApD Services 4: 2: Worldwide Emergency Coverage 4: 2: Worldwide Urgent Coverage 4: 2: Worldwide Emergency Transportation 7b: Other Chiropractic Care 7b: 2: Other Chiropractic Services 7f: Podiatry Services 10b1: Transportation Services - Plan Approved Health-related Location 10b2: Transportation Services - Any Health-related Location 10b2: Transportation Services - Any Health-related Location 10b2: Transportation Services - Any Health-related Location 10b2: Transportation Services - No Max Plan Benefit Amount: Image: Stress Image: Stress Image: Stress St he enrollee limited to one or more of the combined supplemental benefits must select in advance?								
1a: Inpatient Hospital-Acute Inpatient Hospital Psychiatric Skilled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services 3-2: Intensive Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 3-4: SET for PAD Services 4-1: Worldwide Emergency Coverage 4-2: Worldwide Emergency Coverage 4-2: Worldwide Emergency Coverage 4-2: Worldwide Emergency Coverage 4-2: Worldwide Emergency Transportation 701: Routine Chiropractic Care 712: Other Chiropractic Care 714: Acutent Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount? C Yes No Max Plan Benefit Amount: Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? C Yes 		benefits are included in	your Combin	ed Supplemental Bene	efit			
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13a: Acupuncture ✓ Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount? ✓ ○ Yes ✓ Max Plan Benefit Amount: ✓ Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? ✓ ○ Yes ✓			Location					
maximum plan benefit amount? C Yes C No Max Plan Benefit Amount: Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? C Yes		iouni-rolatou Eoouton			~			
O No Max Plan Benefit Amount: Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? O Yes	Do you offer Combined Supplementa maximum plan benefit amount?	al Benefits with a shared	1					
Max Plan Benefit Amount: Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? Yes								
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	C No							
benefits from the package which they must select in advance? Yes	Max Plan Benefit Amount:							
benefits from the package which they must select in advance? Yes								
	Is the enrollee limited to one or more benefits from the package which the	of the combined supple y must select in advance	emental e?					
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CY 2021 PBP Data Entry System Screens

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Optional Supplemental – Management Screen

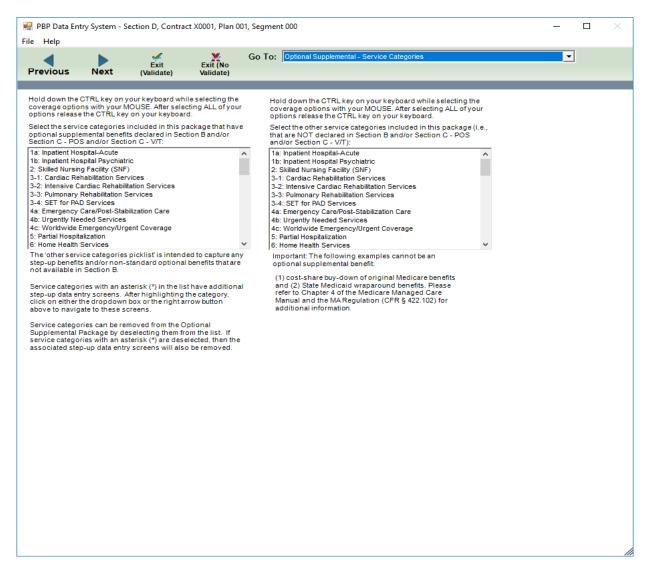
Republic PBP Data Entry System - Section D, Contract X0001, Plan 001, File Help	Segment 000	-	×
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Exit Exit (No	Note: To add an optional supplemental package, click on the 'Add Package button. To delete an optional supplemental package, highlight the existing package and then click on the 'Delete Package' button.		
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Optional Supplemental – Label and Premium

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Optional Supplemental Benefits ID: Optional Supplemental Package Description: Indicate Optional Supplemental Premium Amount: Is there a Maximum Plan Benefit Coverage Amount for this package? Yes No Indicate Maximum Plan Benefit Coverage Amount for this package? Select the Maximum Plan Benefit Coverage Amount for this package: Every three years Every three years Every three months Other, Describe Do the Optional Supplemental benefits in this package apply to the MOOP for this plan? Yes No	Select the benefits to which the deductible applies: 1a: Inpatient Hospital-Acute 1b: Inpatient Hospital Paychiatric 2: Skiled Nursing Facility (SNF) 3: Intensive Cardiac Rehabilitation Services 3: Pulmonary Rehabilitation Services 4: SET for PAD Services 4: Berrgency/Post-Stabilization Services 4: Urgently Needed Services 7: Worldwide Emergency/Urgent Coverage 8: Worldwide Emergency/Urgent Services 7: Oriopractic Services 7: Oriopractic Services 7: Occupational Therapy Services 7: Podiatry Services 7: Other Heath Care Professional 7: Prysical Therapy and Speech-Language Pathology Services 7: Opioid Treatment Program Services 8: Opioid Treatment Program Services <tr< td=""><td></td><td></td></tr<>		
C Yes C No Indicate Deductible Amount:			

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Optional Supplemental – Service Categories



Optional Supplemental – OON Step-up

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C Yes C Yes C No Enter Minimum Copayment Amount: C Yes Enter Minimum Copayment Amount: C Yes Enter Maximum Copayment Amount: Is there an OON Coinsurance? Enter Maximum Copayment Amount: C Yes No Enter Minimum Coinsurance Percentage: Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes: Notes:	Exit Exit No	Go To: Optional Supplemental - OON Step-up	_	
	Does this category include Out-of-Network benefits? C Yes No Are the OON cost shares the same as the In-Network cost shares? C Yes No Is there an OON Coinsurance? C Yes No Enter Minimum Coinsurance Percentage:	C Yes No Enter Minimum Copayment Amount: Enter Maximum Copayment Amount: Enter Maximum Copayment Amount: Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.		

Optional Supplemental – OON Optional

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Does this categ Yes No Are the OON of cost shares? Yes No Is there an OC Yes No Enter Minimut Enter Maxim

Step-up #10b Transportation Services – Base 1

evious Next (Validate) Valid		Base 1
Exit Exit	(No	•Base 1 Indicate number of trips for Any Health-related Location:

Step-up #10b Transportation Services – Base 2

revious Next	Exit Exit (N (Validate) Validate		ervices - Base 2
there a service-specific M overage amount? Nes No Indicate Maximum Plan Bene Every three years Every three years Every year Every year Every yix months Every three months Other, Describe	nefit Coverage amount:	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every three years Every three months Other, Describe	Is there an enrollee Coinsurance?

Step-up #10b Transportation Services – Base 3

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Indicate Maxi	num Copayn mum Copayn required?	ent? nent amount per tri sportation Service	ip:		Transportation Services Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:	✓	

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	Go To: Step-up #16a Preventive Dental - Base 1 (No date)	
CLICK FOR DESCRIPTION OF BENEFIT Does the plan provide Preventive Dental Items as a supplemental benefit under Part C? Yes Oral Exams Prophylaxis (Cleaning) Elect enhanced benefits Oral Exams Prophylaxis (Cleaning) Dental X-Rays Select type of benefit for Oral Exams: Mandatory Optional Is this benefit unlimited for Oral Exams? Yes No, indicate number Indicate number of visits for Oral Exams:	Select the Oral Exams periodicity: Every three years Every six months Other, Describe Select type of benefit for Prophylaxis (Cleaning): Mandatory Optional Is this benefitunlimited for Prophylaxis (Cleaning): Yes No, indicate number Indicate number of visits for Prophylaxis (Cleaning): Select the Prophylaxis (Cleaning) periodicity: Every three years Every three months Other, Describe	Select type of benefit for Fluoride Treatment: Optional st his benefit unlimited for Fluoride Treatment? Yes Indicate number of visits for Fluoride Treatment: Select the Fluoride Treatment periodicity: Cevry three years Every six months Cevry three months Other, Describe

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Previous Next (Validate)	Go To: Step-up #16a Preventive Dental - Base 2 Exit (No Validate)	_	
Select type of benefit for Dental X-Rays: Mandatory Optional Is this benefit unlimited for Dental X-Rays? Yes No, indicate number Indicate number of visits for Dental X-Rays: Select the Dental X-Rays periodicity: Every three years Every three years Every six months Every three months Other, Describe	Is there a service-specific Maximum Plan Benefit Coverage amount? Yes No Does the Maximum Plan Benefit Coverage amount apply to Innetwork services only OR does it apply to both Innetwork and Out-of-network services? Innetwork services only Both Innetwork and Out-of-network services Indicate Maximum Plan Benefit Coverage amount: Select the Maximum Plan Benefit Coverage periodicity: Every three years Every three years Every three months Other, Describe		

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Previous Next (Validate)	Go To: Step-up #16a Preventive Dental - Base 3	_
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount: Every three years Every three months Other, Describe Is there an enrollee Coinsurance? Yes No Select which Preventive Dental Services have a Coinsurance (Select all that apply): Oral Exams Prophylaxis (Cleaning) Fluoride Treatment Dental X-Rays	single cost per Office Visit? Yes No Select which combination of services are included in a single cost per Office Visit: Oral Exams Prophylaxis (Cleaning) Fluoride Treatment Dental X-Rays Indicate Minimum Coinsurance percentage for Office Visits: Indicate Maximum Coinsurance percentage for Office Visits:	Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning): Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning): Indicate Minimum Coinsurance percentage for Fluoride Treatment: Indicate Maximum Coinsurance percentage for Dental X-Rays: Indicate Maximum Coinsurance percentage for Dental X-Rays: Indicate Maximum Coinsurance percentage for Dental X-Rays:

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· · · · · · · · · · · · · · · · · · ·	6a Preventive Dental - Base 4
C Yes	nimum Copayment amount for Office Visit:
C No Indicate Deductible Amount:	ximum Copayment amount for Office Visit:
Indicate Mi	nimum Copayment amount for Oral Exams:
C No	ximum Copayment amount for Oral Exams:
(Select all that apply):	nimum Copaymentamount for Prophylaxis (Cleaning):
Fluoride Treatment Dental X-Rays	ximum Copayment amount for Prophylaxis (Cleaning):
Office Visit?	nimum Copayment amount for Fluoride Treatment:
Select which combination of services are included in a single	ximum Copayment amount for Fluoride Treatment:
Oral Exams Prophylaxis (Cleaning) Foundation of the second	ximum Copayment amount for Dental X-Rays:
Dental X-Rays	

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revious	Next	Exit (Validate)	Exit (No Validate)	Go To:	Step-up #16a Preventive Den	tal - Base 5	•	
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ੇ Yes ∂No								
	uired for Prev	entive Dental Ser	vices?					
ੇ Yes ∂No								
ote may inclu	tal Services N de additional i ot repeat infori	lotes nformation to des mation captured in	cribe benefit in t n data entry.	this service				
ites:							 ^	
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e Help			
Previous Next (Validate)	Go To: Step-up #16b Comprehensive Exit (No Validate)	Dental - Base 2	3
Select type of benefit for Endodontics: Optional Is this benefit unlimited for Endodontics? Yes No, indicate number Indicate number of visits for Endodontics: Select the Endodontics periodicity: Every three years Every two years Every sear Every sear Other, Describe	Select type of benefit for Periodontics: Optional Is this benefit unlimited for Periodontics? Yes No, indicate number Indicate number of visits for Periodontics: Select the Periodontics periodicity: Every three years Every year Every year Every six months Every three months Other, Describe	Select type of benefit for Extractions: Mandatory Optional Is this benefit unlimited for Extractions? Yes No, indicate number Indicate number of visits for Extractions: Every three years Every three years Every three months Other, Describe	Select type of benefit for Prosthodontics, Othe Oral/Maxillofacial Surgery, Other Services: Mandatory Optional Is this benefit unlimited for Prosthodontics, Oth Oral/Maxillofacial Surgery, Other Services? Yes No, indicate number Indicate number of visits for Prosthodontics, of Oral/Maxillofacial Surgery, Other Services: Select the Prosthodontics/Other Oral/Maxillo Surgery/Other Services periodicity: Every three years Every three years Every six months Every six months Other, Describe

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Previous Next (Validate) Go To: Step-up #16b	Comprehensive Dental - Base 3
C Yes C No Select the Maximum Plan Benefit Coverage type: Select Select C Covered under Preventive Dental Category 16a C C C Plan-specified amount per period India Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services? India C In-network services only Selection C In-network and Out-of-network services C Indicate Maximum Plan Benefit Coverage amount: C C	

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s there an enro	llee Coinsura	nce?			Is there an enrollee Deductible?		
C Yes					O Yes		
C No					C No		
	omprehensive	Dental Services	have a Coinsur	ance (Select	all		
that apply): Medicare-co		_			Indicate Deductible Amount:		
Non-routine		5					
Diagnostic S							
Restorative							
Endodontics							
Periodontics	;						
Extractions							
Prosthodon	tics, Other Ora	al/Maxillofacial Su	rgery, Other Se	rvices			
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there an enrollee Copayment? Yes No elect which Comprehensive Dential Services have a Copayment (Select all tatappi): Medicare-covered Benefits Periodontics Periodontics Copayment Minimum Copayment Maximum tedicare-covered Benefits inagnostic Services inagnostic Se	e Help	×	Go To: Step-up #16b Comprehensive Dental - Base 5	•	
No elect which Comprehensive Dental Services have a Copayment (Select all intarphy): Medicare-covered Benefits Diagnostic Services Endodontics Extractions Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Idagnostic Services Copayment Minimum Copayment Minimum Copayment Minimum Idagnostic Services Inagnostic Services Indodontes Indodontes Indodontes Indodontes Indodontes Indodontes Indodontes Intractions Intractions Indodontes Intractions Intractions Intractions Intractions Intractions Intractions Intractions Intractions Intractions	Previous Next	Exit Exit ((Validate) Valida			
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Restorative Services Endodontes Periodontics Extractions Copayment Minimum Copayment Minimum Copayment Minimum Medicare-covered Benefits Non-routine Services Diagnostic Services Endodontes Periodontics Endodontes					
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Medicare-covered Benefits	Endodontics				
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Copayment Minimum Medicare-covered Benefits Medicare-covered Benefits Non-routine Services Diagnostic Services Restorative Services Endodontics Periodontics Periodontics Periodontics, Other Prosthodontics, Other					
Copayment Minimum Copayment Maximum Medicare-covered Benefits					
Medicare-covered Benefits	Prosthodontics, Other Oral	/Maxillofacial Surgery, Oth	er Services		
Medicare-covered Benefits	Co	payment Minimum	Copayment Maximum		
Non-routine Services					
Diagnostic Services	Medicare-covered benefits				
Diagnostic Services	Non-routine Services				
Restorative Services					
Restorative Services	Diagnostic Services				
Endodontics Periodontics Periodontics Prosthodontics, Other Oral/Maxillofacial Surgery,					
Periodontics	Restorative Services				
Periodontics		,	1		
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Extractions Prosthodontics, Other Oral/Maxillofacial Surgery,		-			
Prosthodontics, Other Oral/Maxillofacial Surgery.	Periodontics				
Prosthodontics, Other Oral/Maxillofacial Surgery.					
Oral/Maxillofacial Surgery.	Extractions				
Oral/Maxillofacial Surgery.					
Other Services:	Oral/Maxillofacial Surgery.				
	Other Services:				

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Is authorization	n required?						
O No	uired for Com	prehensive Denta	Services?				
C Yes C No							
Comprehensiv Note may includ category. Do no	de additional i	ices Notes information to des mation captured ir	cribe benefit in t 1 data entry.	his service			
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Step-Up #17a Eye Exams – Base 1

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	► S	Exit (No	Go To: Step-up #17a Eye Exams - Base 1	▼	
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CLICK FOR DESC	CRIPTION OF BENEFIT		Enter name of Other Service:	Is there a service-specific Maximum Plan Benefit Coverage amount?	Is there a service-specific Maximum Enrollee Out- of-Pocket Cost?
Does the plan prov	ide Eye Exams as a suppleme	ntal		O Yes	C Yes
benefit under Part C	?		Select type of benefit for Other Service:	C No	C No
C Yes C No			C Mandatory C Optional	Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?	Indicate Maximum Enrollee Out-of-Pocket Cost amount:
Select enhanced t			Is this benefit unlimited for Other Service?	C In-network services only	
C Other			O Yes	C Both In-network and Out-of-network services	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:
Select type of ber	nefit for Routine Eye Exams:		C No, indicate number	Indicate Maximum Plan Benefit Coverage amount:	C Every three years
C Mandatory			Indicate quantity for Other Service:		C Every two years C Every year
C Optional				Select the Maximum Plan Benefit Coverage periodicity:	C Every six months
Is this benefit	unlimited for Routine Eye Exa	ms?	Select the Other Service periodicity:	C Every three years	C Every three months C Other, Describe
C Yes C No, indica	ate number		 Every three years Every two years 	C Every two years C Every year	
Indicate numb	per of exams for Routine Eye E	xams:	C Every year	C Every six months	
			C Every six months C Every three months	C Every three months C Other, Describe	
Select the Routi	ne Eye Exams periodicity:		C Other, Describe		
C Every three					
C Every two ye C Every year	ears				
C Every six mo C Every three					
O Other, Desc					

Step-Up #17a Eye Exams – Base 2

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there an enro) Yes) No	llee Coinsura	ince?			Is there an enrollee Copayment?	Is there an enrollee Deductible? C Yes C No	
Medicare-co Routine Eye Other	vered Benefi Exams	e a Coinsurance (ts ance percentage fo			Select which Eye Exams have a Copayment (Select all that apply): Medicare-covered Benefits Content Covered Benefits: Cother Indicate Minimum Copayment amount for Medicare-covered Benefits:	Indicate Deductible Amount:	
Indicate Maxi Benefits:	num Coinsur	ance percentage f	or Medicare-cov	vered	Indicate Maximum Copayment amount for Medicare-covered Benefits:		
Indicate Minii	num Coinsura	ance percentage f	or Routine Eye f	Exams:	Indicate Minimum Copayment amount for Routine Eye Exams:		
Indicate Maxi	mum Coinsur	ance percentage	or Routine Eye	Exams:	Indicate Maximum Copayment amount for Routine Eye Exams:		
Indicate Minir	num Coinsura	ance percentage fo	or Other Service	c	Indicate Minimum Copayment amount for Other Service:		
Indicate Maxi	mum Coinsur	ance percentage f	or Other Servic	ð:	Indicate Maximum Copayment amount for Other Service:		

Step-Up #17a Eye Exams – Base 3

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Is authorization	required?												
Is a referral req	uired for Eye I	Exams?											
C No Eye Exams Not Note may includ category. Do no	le additional i	nformation to des mation captured ir	cribe benefit in t n data entry.	his service	•								
Notes:										 		^	
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	Select type of benefit for Contact lenses: Optional Is this benefit unlimited for Contact lenses? Yes No, indicate number Indicate quantity (number of pairs) for Contact lenses: Select Contact lenses periodicity: Every three years Every year Every year Every three nonths Other, Describe	Select type of benefit for Eyeglasses (lenses and frames): Optional Is this benefit unlimited for Eyeglasses (lenses and frames)? O to indicate number Indicate quantity for Eyeglasses (lenses and frames): Select Eyeglasses (lenses and frames) Select Eyeglasses (lenses and frames) Select Eyeglasses (lenses and frames): Select Eyeglasses (lenses and frames) Other, Describe

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revious Next (Validate) Validat	Go To: Step-up #17b Eyewear - Base 2 o e)	•
elect type of benefit for Eyeglass lenses:	Select type of benefit for Eyeglass frames:	
Mandatory Optional	C Mandatory C Optional	
this benefit unlimited for Eyeglass lenses?	Is this benefit unlimited for Eyeglass frames?	
Yes No, indicate number	C Yes C No, indicate number	
ndicate quantity (number of pairs) for Eyeglass lenses:	Indicate quantity for Eyeglass frames:	
Select Eyeglass lenses periodicity:	Select Eyeglass frames periodicity:	
C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	C Every three years Every two years Every year Every six months Every three months Other, Describe	
	Select type of benefit for Upgrades:	
	○ Mandatory ○ Optional	

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Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes C No	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	Indicate Minimum Coinsurance percentage for Eyeglass frames:
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Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Minimum Coinsurance percentage for Contact lenses:	Indicate Minimum Coinsurance percentage for Upgrades:
Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years E Every two years E Every year E Every six months E Every three months O Other, Describe	Indicate Maximum Coinsurance percentage for Contact lenses:	Indicate Maximum Coinsurance percentage for Upgrades:
Is there an enrollee Coinsurance? C Yes C No	Indicate Maximum Coinsurance percentage for Eyeglasses (lenses and frames):	
Select which Eyewear Benefits have a Coinsurance (Select all that apply): Medicare-covered Benefits Contact lenses Eyeglasses (lenses and frames) Eyeglass lenses Eyeglass frames Upgrades	Indicate Minimum Coinsurance percentage for Eyeglass lenses:	

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Yes No Select which Hearing Exam Benefits have a Copayment (Select all that apply): Medicare-covered Benefits Routine Hearing Exams Fitting/Evaluation for Hearing Aid Indicate Minimum Copayment amount for Medicare-covered Benefits: Indicate Maximum Copayment amount for Medicare-covered Benefits: Indicate Maximum Copayment amount for Routine Hearing Exams: Indicate Minimum Copayment amount for Routine Hearing Exams:		Exit	Exit (No Validate)	Go To:	Step-up #18a Hearing Exams - Base 3	
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	Ves No Select which Hearing Exa Medicare-covered Be Routine Hearing Exa Fitting/Evaluation for Indicate Minimum Copay Indicate Maximum Copay Indicate Minimum Copay Indicate Maximum Copay	am Benefits have a C inefits ms Hearing Aid yment amount for Me yment amount for Ro yment amount for Ro yment amount for Fitti	Copayment (Se dicare-covered adicare-covered utine Hearing E putine Hearing i ing/Evaluation	l Benefits: d Benefits: Exams: Exams: for Hearing A	O Yes O No pply): Is a referral required for Hearing Exams? O Yes O No	

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Hearing Exams	Notes							
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CLICK FOR DESCRIPTION OF BENEFIT	Select type of benefit for Hearing Aids (all types): C Mandatory C Optional	Select type of benefit for Hearing Aids - Inner Ear: C Mandatory C Optional	Select type of benefit for Hearing Aids - Outer Ear: C Mandatory C Optional
upplemental benefit under Part C? 7 Yes 7 No Select enhanced benefits:	Is this benefit unlimited for Hearing Aids (all types)? C Yes C No, indicate number	Is this benefit unlimited for Hearing Aids - Inner Ear?	Is this benefit unlimited for Hearing Aids - Outer Ex C Yes C No, indicate number
Hearing Aids (all types) Hearing Aids - Inner Ear Hearing Aids - Outer Ear Hearing Aids - Over the Ear	Select Hearing Aids (all types) periodicity:	Indicate quantity for Hearing Aids - Inner Ear:	Indicate quantity for Hearing Aids - Outer Ear.
	C Every three years C Every two years C Every year C Every six months C Every three months C Other. Describe	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe
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Previous Exit (Vo (Validate) Exit (No Validate) Select type of benefit for Hearing Aids - Over the Ear: Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined? Mandatory Optional Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined? Is this benefit unlimited for Hearing Aids - Over the Ear? Does the Maximum Plan Benefit Coverage type: Yes No, indicate number Select the Maximum Plan Benefit Coverage type: Covered under Hearing Exams Category - 18a Plan-specified amount per period Does the Maximum Plan Benefit Coverage amount apply to in-network services only OR does it apply to both In-network services only	File Help		
C Mandatory or for both ears combined? C Optional C Per ear Is this benefit unlimited for Hearing Aids - Over the Ear? Both ears combined C Yes Both ears combined C No, indicate number C Indicate quantity for Hearing Aids - Over the Ear: C Covered under Hearing Exams Category - 18a Indicate quantity for Hearing Aids - Over the Ear: Does the Maximum Plan Benefit Coverage amount apply to in-network services only Modes it apply to both In-network and Out-of-network services? Select Hearing Aids - Over the Ear periodicity: C In-network services only	Exit Exit (No		
 Every three years Every two years Every year Every year Other, Describe Indicate Maximum Plan Benefit Coverage periodicity: Indicate Maximum Plan Benefit Coverage periodicity: Every three years Every three months Other, Describe 	 Mandatory Optional Is this benefit unlimited for Hearing Aids - Over the Ear? Yes No, indicate number Indicate quantity for Hearing Aids - Over the Ear: Select Hearing Aids - Over the Ear periodicity: Every three years Every three years Every three years Every six months Other, Describe Is there a service-specific Maximum Plan Benefit Coverage amount? 	or for both ears combined?	

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Indicate Minimum Copayment amount per Hearing Aid - Outer Ear: Indicate Minimum Copayment amount per Hearing Aid - Outer Ear: Indicate Minimum Copayment amount per Hearing Aid - Outer Ear: Indicate Minimum Copayment amount per two Hearing Aid - Outer Ear: Indicate Minimum Copayment amount per two Hearing Aid - Outer Ear: Indicate Minimum Copayment amount per two Hearing Aid - Outer Ear: Indicate Minimum Copayment amount per Hearing Aid Indicate Minimum Copayment amount per Hearing Aid - Over the Ear: Indicate Minimum Copayment amount per Hearing Aid - Indicate Minimum Copayment amount per two Hearing Aid - Over the Ear: Indicate Minimum Copayment amount per Hearing Aid - Indicate Minimum Copayment amount per Hearing Aid - Over the Ear: Indicate Maximum Copayment amount per Hearing Aid - Indicate Minimum Copayment amount per two Hearing Aid - Over the Ear: Indicate Maximum Copayment amount per Hearing Aid - Indicate Maximum Copayment amount per two Hearing Aid - Over the Ear: Indicate Maximum Copayment amount per two Hearing Aid - Over the Ear: Indicate Maximum Copayment amount per two Hearing Aid - Over the Ear: Indicate Maximum Copayment amount per two Hearing Aids - Over the Ear: Indicate Minimum Copayment amount per two Hearing Aids - Over the Ear: Indicate Minimum Copayment amount per two Hearing Aids - Over the Ear: Indicate Minimum Copayment amount per two Hearing Aids - Over the Ear: Indicate Minimum Copayment amount per two Hearing Aids - Over the Ear: Indicate Minimum Copayment amount per two Hearing Aids - Over the Ear: Indicate Maximum Copayment amount per two Hearing Aids - Over the Ear: Indicate Minimum Copayment amount per two Hearing Aids - Over the Ear: Indicate Maximum Cop
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C No Hearing Aids N Note may includ category. Do no	de additional i	nformation to des mation captured ir		this service			
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Step-up #7b Chiropractic Services – Base 1

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	ined benefit (S	efits that are included Select all that apply):			

Step-up #7b Chiropractic Services – Base 2

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here an enrollee Coinsurance?	Is there an enrollee Copayment?	Is there an enrollee Deductible?
Yes No	O Yes O No	O Yes O No
Select which Chiropractic Services have a Coinsurance (Select all that apply): Medicare-covered Chiropractic Services Routine Care Other	Select which Chiropractic Services have a Copayment (Select all that apply): Medicare-covered Chiropractic Services Routine Care	Indicate Deductible Amount:
Indicate Minimum Coinsurance percentage per visit for Medicare-covered Benefits:	Indicate Minimum Copayment amount for Medicare- covered Benefits:	C Yes C No
Indicate Maximum Coinsurance percentage per visit for Medicare-covered Benefits:	Indicate Maximum Copayment amount for Medicare- covered Benefits:	Is a referral required for Chiropractic Services?
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Step-up #7b Chiropractic Services – Base 3

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Step-up #7f Podiatry Services – Base 1

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CLICK FOR DESCRIPTION OF BENEFIT Does the plan provide Podiatry Services as a supplemental benefit under Part C? Yes Routine Foot Care Select enhanced benefits: Routine Foot Care Select type of benefit for Routine Foot Care C Optional Is this benefit unlimited for Routine Foot Care Ro Indicate number of Routine Foot Care visits:	Select the Routine Foot Care periodicity:	Is there a service-specific Maximum Enrollee Out -of-Pocket Cost? Yes Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select the Maximum Enrollee Out-of-Pocket Costperiodicity: Cevery three years Every three years Every three months Other, Describe

Step-up #7f Podiatry Services – Base 2

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Step-up #7f Podiatry Services – Base 3

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